Bellmore Family Dental
Lee J. Levinson, DDS
and Associates
2814A Merrick Road, Bellmore, NY 11710
Tel (516) 781-7567 Fax (516) 781-7580

MEDICAL HISTORY

DENTAL INSURANCE

DATE __________ DRIVERS LIC. # ____________________

PATIENT NAME ____________________

ADDRESS ____________________

CITY ____________________ STATE ______ ZIP ________

HOME PHONE __________ BUSINESS PHONE __________

CELL PHONE __________ E-MAIL __________

EMPLOYER ____________________

S.S.# ____________________ BIRTH DATE ________

SEX ❑ MALE ❑ FEMALE MARITAL STATUS ________

WHO MAY WE THANK FOR REFERRING YOU? ____________________

____

DENTAL INSURANCE (Primary) ____________________

SUBSCRIBER NAME ____________________

SUBSCRIBER S.S.# ____________________ D.O.B. ________

SUBSCRIBER EMPLOYER ____________________

DENTAL INSURANCE (Secondary) ____________________

SUBSCRIBER NAME ____________________

SUBSCRIBER S.S.# ____________________ D.O.B. ________

SUBSCRIBER EMPLOYER ____________________

PHYSICIAN NAME ____________________

PHYSICIAN NUMBER ____________________

SIGNATURE OF THE PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT. X ____________________

REASON FOR TODAY'S VISIT. ____________________

MEDICAL HISTORY - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you, it is necessary to have the following information.

HAVE YOU EVER OR NOW HAVE (Please check yes or no):

Y	N		Y	N		Y	N	
☐	☐	Allergies to Medicine	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Allergy to Penicillin	☐	☐	Drug or Alcohol Abuse	☐	☐	Leukemia
☐	☐	Anemia	☐	☐	Emotional Disturbance	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Asthma	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Bladder Conditions	☐	☐	Excessive Bleeding Problem	☐	☐	Pacemaker
☐	☐	Blood Pressure Problems	☐	☐	Fainting or Dizziness	☐	☐	Pneumonia
☐	☐	Blood Transfusions	☐	☐	Frequent Infections	☐	☐	Rheumatic Fever
☐	☐	Birth Defects	☐	☐	Hay Fever	☐	☐	Scoliosis (Curved Spine)
☐	☐	Bone or Joint Problems	☐	☐	Hearing/Speech Problem	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Heart Murmur/Heart Defects	☐	☐	Sinus Problems
☐	☐	Bruising Easily	☐	☐	Heart Surgery	☐	☐	Thyroid Problems
☐	☐	Cancer or Malignancies	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Hepatitis or Liver Disease	☐	☐	Ulcers/Stomach Problems
☐	☐	Chronic Headaches	☐	☐	HIV Positive	☐	☐	Venerial Disease/Herpes
☐	☐	Cleft Lip/Palate	☐	☐	Implants	☐	☐	Other __________
☐	☐	Convulsions/Seizures	☐	☐	Jaundice			__________

Do wounds heal slowly or present complications? ☐ Yes ☐ No

Presently taking medication? (Please Specify) ____________________

Presently under a physician's care? ☐ Yes ☐ No

When was your last physical exam? __________

Have you ever been hospitalized? Date (s) __________ Reason (s) __________

Have you ever had x-ray treatment or chemotherapy? ☐ Yes ☐ No

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered: ____________________

____

(OVER)

DATE OF LAST DENTAL EXAM ______	**MEDICAL INSURANCE INFO.**
DATE OF LAST FULL MOUTH X-RAY ______	GROUP NO. ______
OFFICE TAKEN ______	NAME OF MEDICAL INS. ______
	SUBSCRIBER S.S. # ______

		YES	NO
1.	Have you had trouble from previous dental care? When? Explain.		
2.	Do you have pain in your jaw or near your ears?		
3.	Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4.	Have you experienced any growths or sore spots in your mouth?		
5.	Does any part of your mouth hurt when clenched?		
6.	Have you ever had Novocaine or other local anesthetic?		
7.	Have you ever had Nitrous Oxide (laughing gas)?		
8.	Have you ever had general anesthesia?		
9.	Have you ever had any reaction/allergic symptoms to Novocaine, local or general anesthetic?		
10.	Have you ever had any difficult extractions in the past?		
11.	Have you ever had prolonged bleeding following extractions in the past?		
12.	Do your gums bleed?		
13.	Do you have a bad taste in your mouth or mouth odor?		
14.	Have you ever had instructions on the care of your gums?		
15.	Do you chew on only one side of your mouth? If so, why?		
16.	Do you habitually clench or grind your teeth during the night or day?		
17.	Is any part of your mouth sensitive to pressures or irritants (hot, cold or sweets)? Where?		

Is there any other problem not covered above that you would like to discuss?______

I acknowledge that the information above on the reverse side is correct:

PATIENT SIGNATURE DATE
(Parent if Patient is a Minor)

DOCTOR SIGNATURE DATE

FUTURE RECALL MEDICAL HISTORY UPDATES

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______
PRINT NAME ______ SIGNATURE ______ DATE ______ DR. ______

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______
PRINT NAME ______ SIGNATURE ______ DATE ______ DR. ______

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______
PRINT NAME ______ SIGNATURE ______ DATE ______ DR. ______

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______
PRINT NAME ______ SIGNATURE ______ DATE ______ DR. ______

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain ______
PRINT NAME ______ SIGNATURE ______ DATE ______ DR. ______